		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006767

Facility Name: Beulah Land Christian Home

Address: 201 East Falcon Hwy - Box C (Number) Flanagan (City) 61740 (Zip Code)

County: Livingston

Telephone Number: 815-796-2267 **Fax #** ( )

IDPA ID Number: 37-0841562008

Date of Initial License for Current Owners: 1969

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501c3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2002 to June 30, 2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financical Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke LLP, 600 East Adams Springfield IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,680	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,782	2,954	947	10,683	8
9	SNF/PED					9
10	ICF	1,980	1,096		3,076	10
11	ICF/DD					11
12	SC	2,386	3,803		6,189	12
13	DD 16 OR LESS					13
14	TOTALS	11,148	7,853	947	19,948	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.87%

D. How many bed-hold days during this year were paid by Public Aid? 254 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 43 and days of care provided 947

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	132,757	16,019	6,266	155,042		155,042		155,042			1
2	Food Purchase		102,854		102,854		102,854	(173)	102,681			2
3	Housekeeping	95,179	20,919		116,098		116,098		116,098			3
4	Laundry											4
5	Heat and Other Utilities			65,833	65,833		65,833	(3,525)	62,308			5
6	Maintenance	29,957	26,465		56,422		56,422	4,480	60,902			6
7	Other (specify):*											7
8	**TOTAL General Services**	257,893	166,257	72,099	496,249		496,249	782	497,031			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	722,325	87,639	3,479	813,443		813,443	(100)	813,343			10
10a	Therapy			76,968	76,968		76,968		76,968			10a
11	Activities	18,628			18,628		18,628	(1,086)	17,542			11
12	Social Services	56,139	535	4,761	61,435		61,435		61,435			12
13	Nurse Aide Training											13
14	Program Transportation			268	268		268		268			14
15	Other (specify):* Contracted Salaries			78,164	78,164		78,164		78,164			15
16	**TOTAL Health Care and Programs**	797,092	88,174	163,640	1,048,906		1,048,906	(1,186)	1,047,720			16
	C. General Administration											
17	Administrative	51,557	1,063	104,652	157,272		157,272	(79,362)	77,910			17
18	Directors Fees											18
19	Professional Services			44,172	44,172		44,172	3,830	48,002			19
20	Dues, Fees, Subscriptions & Promotions			23,099	23,099		23,099	(4,050)	19,049			20
21	Clerical & General Office Expenses	25,524	2,956	14,153	42,633		42,633	43,576	86,209			21
22	Employee Benefits & Payroll Taxes			208,976	208,976		208,976	10,647	219,623			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,924	12,924		12,924	3,629	16,553			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			51,865	51,865		51,865	1,600	53,465			26
27	Other (specify):*											27
28	**TOTAL General Administration**	77,081	4,019	459,841	540,941		540,941	(20,130)	520,811			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,132,066	258,450	695,580	2,086,096		2,086,096	(20,534)	2,065,562			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Beulah Land Christian Home #0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			125,449	125,449		125,449	6,655	132,104			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,540	43,540		43,540	(1,607)	41,933			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			168,989	168,989		168,989	5,048	174,037			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			541	541		541		541			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			24,084	24,084		24,084		24,084			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,132,066	258,450	888,653	2,279,169		2,279,169	(15,486)	2,263,683			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(425)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,207)	5		5
6	Rented Facility Space	(3,000)	5		6
7	Sale of Supplies to Non-Patients	(100)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(27,107)	32		10
11	Discounts, Allowances, Rebates & Refunds	105	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	35,639	21		24
25	Fund Raising, Advertising and Promotional	(4,050)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(4,694)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,839)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(8,647)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,647)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (15,486)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Beulah Land Christian Home

ID# 0006767

Report Period Beginning: July 1, 2002

Ending: June 30, 2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 252	2	1
2	Activity	(1,086)	11	2
3	Marketing Expense	(22,737)	21	3
4	Loss on Disposal	(5,942)	21	4
5	Miscellaneous	(681)	21	5
6	Exempt Interest Income - Endowment	25,500	32	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,694)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(173)	0	0	0	0	0	0	0	0	0	0	(173)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,207)	2,682	0	0	0	0	0	0	0	0	0	(3,525)	5
6	Maintenance	0	4,480	0	0	0	0	0	0	0	0	0	4,480	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,380)	7,162	0	0	0	0	0	0	0	0	0	782	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(100)	0	0	0	0	0	0	0	0	0	0	(100)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,086)	0	0	0	0	0	0	0	0	0	0	(1,086)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,186)	0	0	0	0	0	0	0	0	0	0	(1,186)	16
	C. General Administration													
17	Administrative	0	(79,362)	0	0	0	0	0	0	0	0	0	(79,362)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,830	0	0	0	0	0	0	0	0	0	3,830	19
20	Fees, Subscriptions & Promotions	(4,050)	0	0	0	0	0	0	0	0	0	0	(4,050)	20
21	Clerical & General Office Expenses	6,384	37,192	0	0	0	0	0	0	0	0	0	43,576	21
22	Employee Benefits & Payroll Taxes	0	10,647	0	0	0	0	0	0	0	0	0	10,647	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,629	0	0	0	0	0	0	0	0	0	3,629	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,600	0	0	0	0	0	0	0	0	0	1,600	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	2,334	(22,464)	0	0	0	0	0	0	0	0	0	(20,130)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,232)	(15,302)	0	0	0	0	0	0	0	0	0	(20,534)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	6,655	0	0	0	0	0	0	0	0	0	6,655	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,607)	0	0	0	0	0	0	0	0	0	0	(1,607)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,607)	6,655	0	0	0	0	0	0	0	0	0	5,048	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,839)	(8,647)	0	0	0	0	0	0	0	0	0	(15,486)	45

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes Inc	100.00%	$ 2,682	$ 2,682	1
2	V	6	Maintenance				4,480	4,480	2
3	V	17	Administrative	104,652			25,290	(79,362)	3
4	V	19	Professional Services				3,830	3,830	4
5	V	21	Clerical				37,192	37,192	5
6	V	22	Employee Benefits				10,647	10,647	6
7	V	24	Travel & Seminar				3,629	3,629	7
8	V	26	Insurance				1,600	1,600	8
9	V	30	Depreciation				6,655	6,655	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 104,652			$ 96,005	$ * (8,647)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: ne 30, 2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1996-A GR Bonds	x		Operations	$1,740.53	07/01/96	$ 225,000	$ 199,575	07/01/21	0.0700	$ 14,095	1
2	1998-C GR Bonds	x		Operations	$8,081.11	11/01/98	480,060	148,133	01/05/05	0.0700	12,598	2
3	2001-X GR Bonds	x		Operations	$1,166.67	10/01/01	200,000	200,000	10/01/31	0.0700	14,000	3
4	Bond Financing Fee										816	4
5												5
	Working Capital											
6	CHI Bond Fund	x		Working Capital	$3,000.00	N/A	121,883		N/A	0.0850	2,031	6
7												7
8												8
9	TOTAL Facility Related				$13,988.31		$ 1,026,943	$ 547,708			$ 43,540	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,026,943	$ 547,708			$ 43,540	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beulah Land Christian Home COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0006767

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-13-27-226-004	S27 T28 R3	$ 163.28	$
2.	13-13-27-203-001	S27 T28 R3	$ 440.14	$
3.	13-13-27-201-012	S27 T28 R3	$ 2,179.50	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 2,782.92	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,000	Various	$ 19,470	1
2	Home Office			3,551	2
3	TOTALS	16,000		$ 23,021	3

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1982	1982	$ 1,279,926	$ 31,998	40	$ 31,998	$	$ 673,291	4
5	32		1974	1974	417,998	8,360	50	8,360		272,977	5
6											6
7											7
8	Home Office Allocation				25,958	746		746		13,406	8
	Improvement Type**										
9	Land Improvement			1977	7,756	155	50	155		4,109	9
10	Insulated Windows			1979	16,273	370	44	370		8,757	10
11	Smoke Detectors			1979	1,797		15			1,797	11
12	Ceiling Replaced			1981	1,118	26	43	26		598	12
13	Heating & A/C			1982	25,614		20			25,614	13
14	Bldg Improvement			1982	28,428	711	40	711		14,961	14
15	Bldg Improvement			1982	7,375	184	40	184		3,834	15
16	Bldg Improvement			1982	36,352	909	40	909		18,707	16
17	Insulation			1983	4,400	147	30	147		3,013	17
18	Improvements			1983	2,925	98	30	98		1,977	18
19	Hot Water System			1985	1,577	79	20	79		1,455	19
20	Edge Protectors, Etc			1985	507		15			507	20
21	Light Fixtures			1985	406		15			406	21
22	Garage Work			1985	23,170		15			23,170	22
23	Ceiling Tiles			1985	225		15			225	23
24	Bldg Improvement			1986	36,762	919	40	919		16,083	24
25	Light Fixtures - 1/2			1987	610		10			610	25
26	Window 1/2			1987	840	42	20	42		679	26
27	Remodeling 1/2			1987	634	22	15	22		634	27
28	Hot Water System 1/2			1988	979	49	20	49		751	28
29	Chg Water Piping 1/2			1988	390	20	20	20		307	29
30	Water Heater Consult			1988	961	49	15	49		961	30
31	Door Alarm System			1988	1,900	95	20	95		1,409	31
32	Vinyl Siding			1988	3,410	171	20	171		2,522	32
33	Carpeting			1989	860					860	33
34	Door Monitor Panel			1989	1,980		10			1,980	34
35	Compressors (2)			1989	924		10			924	35
36	Compressors			1989	2,306		10			2,306	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Painting Sheltercare	1989	$ 1,594	$	5	$	$	$ 1,594	37
38	Compressor (1)	1989	693		10			693	38
39	Emerg Power Kitchen Light	1990	329		5			329	39
40	Lavatories/Faucets	1990	1,679		5			1,679	40
41	Carpeting	1990	300		5			300	41
42	Compressor	1991	1,828		10			1,828	42
43	Roof Repair	1991	2,340		6			2,340	43
44	Insulating Glass	1991	2,256	68	33	68		793	44
45	Smoke/Heat Detectors	1991	885		10			885	45
46	Door Monitor	1992	1,440	36	10	36		1,440	46
47	Room Windows (3)	1992	2,696	135	20	135		1,451	47
48	A/C Units (5)	1992	5,859		8			5,859	48
49	Energy Management	1991	658	20	10	20		658	49
50	Sinks/Faucets	1993	537		5			537	50
51	Door Monitor	1993	1,700	156	10	156		1,700	51
52	Mix Valve/Faucet	1993	2,953	273	10	273		2,953	52
53	Auto Sprinkler	1993	580	58	10	58		570	53
54	Door Access System	1993	602	60	10	60		580	54
55	Wallcoverings	1993	5,315		5			5,315	55
56	Carpet/Wallpaper	1993	9,540		5			9,538	56
57	Drapes	1994	4,878		10			4,878	57
58	Roofing Project Shelter	1994	62,189	4,146	15	4,146		37,314	58
59	Install Carrier Furnace	1994	1,877	188	10	188		1,676	59
60	Disposer	1994	1,475	148	10	148		1,283	60
61	Nurse Call System	1995	1,040	69	15	69		575	61
62	Upstairs Lib/Comp Room	1995	1,743	174	10	174		1,452	62
63	Garage Doors	1995	676		5			676	63
64	Wanderguard	1995	4,094	409	10	409		3,306	64
65	Smoke/Fire Alarms	1995	957	72	10	72		752	65
66	A/C Heating Units	1995	2,326	265	8	265		2,326	66
67	Smoke Detectors	1995	766	58	10	58		591	67
68	Heating/AC Units	1995	4,652	582	8	582		4,559	68
69	Carrier Central A/C	1995	2,748	275	10	275		2,131	69
70	TOTAL (lines 4 thru 69)		$ 2,067,566	$ 52,342		$ 52,342	$	$ 1,201,391	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,067,566	$ 52,342		$ 52,342	$	$ 1,201,391	1
2	Heating/AC Units	1995	2,326	291	8	291		2,231	2
3	Water Heater	1996	6,263	626	10	626		4,643	3
4	200 Gallon Storage Tank	1996	4,115	412	10	412		3,021	4
5	Remodel Nursing Wing	1996	3,249		5			3,249	5
6	Heating/AC Units	1996	5,235	654	8	654		4,360	6
7	Mixer/Amp	1997	975	98	10	98		604	7
8	Water Heater	1997	13,453	1,345	10	1,345		8,182	8
9	Eyewash Station	1997	555	9	5	9		555	9
10	Exit Lights	1997	1,102	110	10	110		642	10
11	Energy Management System	1997	14,670	734	20	734		4,221	11
12	York C/A Unit	1997	7,839	784	10	784		4,508	12
13	Floor Covering	1997	1,856	94	5	94		1,856	13
14	Wall Covering Sit & Bath	1998	2,574	256	5	256		2,574	14
15	Floor Covering - Sit & Bath	1998	1,145	134	5	134		1,145	15
16	Carpeting	1998	8,739	1,747	5	1,747		8,739	16
17	Wallpaper	1998	7,497	1,499	5	1,499		7,495	17
18	Room Signs	1998	2,270	454	5	454		2,081	18
19	Paint/Wallpaper/Carpet	1999	17,404	1,740	10	1,740		7,830	19
20	Remodel Nurses Station	1999	2,700	180	15	180		750	20
21	Floor Tile/Cove Base	2000	1,144	229	5	229		878	21
22	Carpet/Cove Base 2 Rooms	2000	576	115	5	115		431	22
23	A/C Grill Covers (13)	2000	546	109	5	109		400	23
24	Shelter Care Hallway CA	2000	3,686	737	5	737		2,702	24
25	Floor Covering	2000	1,040	208	5	208		745	25
26	Fire Alarm System	2000	32,965	3,297	10	3,297		11,265	26
27	Floor Tile/Cove Base	2000	1,755	351	5	351		1,199	27
28	Remodel - Chapel/Act/Bs/Dr	2000	10,705	1,071	10	1,071		3,392	28
29	AC HEATING UNIT INSTALLED	2000	505	34	15	34		91	29
30	FLOOR COVERINGS	2000	1,143	229	5	229		592	30
31	ENTRY SYSTEM KEYPAD/ALZ. WING	2001	775	155	5	155		323	31
32	DOOR ALARM SYSTEM	2001	1,155	116	10	116		242	32
33	Mixing Valve Installation	2001	1,649	165	10	165		330	33
34	TOTAL (lines 1 thru 33)		$ 2,229,177	$ 70,325		$ 70,325	$	$ 1,292,667	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,229,177	$ 70,325		$ 70,325	$	$ 1,292,667	1
2	Canopy over patio area	2001	6,612	661	10	661		1,157	2
3	Steel Door/East Side of Kitchen	2001	1,393	139	10	139		220	3
4	Floor Coverings - Rooms 404 & 417	9/27/2002	886	148	5	148		148	4
5	(2) Thru Wall Unit A/C	10/18/2002	1,348	127	8	127		127	5
6	Carrier thru-wall HTG/AC unit	3/27/2003	625	14	15	14		14	6
7	80' Red Oak Handrail & Installation	4/21/2003	2,160	36	15	36		36	7
8	Apartment Conversion	2/1/2003	31,913	887	15	887		887	8
9	Railing - Asst Living Loft Area	4/25/2003	3,456	87	10	87		87	9
10	Wiring run for Steamer & Steam Table	4/4/2003	1,644	21	20	21		21	10
11	Tile Bathrooms - Rooms 414/417/423-Carpet 423	5/30/2003	817	27	5	27		27	11
12	Fully depreciated land improvements	6/30/1974	100,657		20			100,657	12
13	Water & sewer line	11/30/1980	12,325	411	30	411		12,057	13
14	Parking lot lighting	10/31/1983	3,642	182	20	182		3,595	14
15	Sidewalk	11/30/1987	10,600	424	25	424		6,643	15
16	New sidewalk & move fire hydrant	12/12/1989	1,725	95	20	95		3,057	16
17	Outside lights	1/5/1994	2,099	210	10	210		1,995	17
18	Landscaping	6/30/1995	8,515	852	10	852		6,964	18
19	Concrete pad	6/5/1998	3,571	357	10	357		1,815	19
20	Landscaping	8/13/1998	578	116	5	116		570	20
21	Patio	11/17/2000	4,090	409	10	409		1,091	21
22	Landscaping	6/30/2001	1,975	395	5	395		823	22
23	Landscaping and fence	10/25/2001	16,799	1,680	10	1,680		3,108	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Less: disposals		(7,291)					(6,911)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,439,316	$ 77,603		$ 77,603	$	$ 1,430,855	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 288,134	$ 35,431	$ 35,431	$	Various	$ 151,944	71
72	Current Year Purchases	22,252	1,286	1,286		Various	1,286	72
73	Fully Depreciated Assets	199,728				Various	199,728	73
74	Home Office Allocation	45,050	4,770	4,770			24,942	74
75	TOTALS	$ 555,164	$ 41,487	$ 41,487	$		$ 377,900	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2000 Ford Van	2000	$ 47,500	$ 11,875	$ 11,875	$	4	$ 37,604	76
77										77
78										78
79	Home Office Allocation			5,190	1,139	1,139			2,382	79
80	TOTALS			$ 52,690	$ 13,014	$ 13,014	$		$ 39,986	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,070,191	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,104	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,104	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,848,741	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 202,868	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 202,868	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Feasibility Costs	$ 1,402	92
93			93
94			94
95		$ 1,402	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,968	$	1
2	Cash-Patient Deposits	6,697		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,388)	227,352		3
4	Supply Inventory (priced at FIFO)	20,534		4
5	Short-Term Investments	11,503		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	4,793		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 275,847	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	222,338		13
14	Buildings, at Historical Cost	2,246,784		14
15	Leasehold Improvements, at Historical Cost	166,575		15
16	Equipment, at Historical Cost	557,617		16
17	Accumulated Depreciation (book methods)	(1,803,324)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	519,015		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	1,402		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,910,407	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,186,254	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,082	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,697		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,547		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,007		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 130,333	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	547,708		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 547,708	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 678,041	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,508,213	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,186,254	$	48

***(See instructions.)**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,582,969	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,582,969	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(49,760)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (49,760)	17
	B. Transfers (Itemize):		
18	**Transfer Out to Affiliate**	(24,996)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (24,996)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,508,213	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,429,559	1
2	Discounts and Allowances for all Levels	(554,155)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,875,404	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	112,631	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 112,631	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	425	14
15	Telephone, Television and Radio	3,207	15
16	Rental of Facility Space	3,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	100	18
19	Laboratory	639	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,384	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,755	23
	D. Non-Operating Revenue		
24	Contributions	206,293	24
25	Interest and Other Investment Income***	27,107	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 233,400	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investments/Sale of Equipment	(5,781)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (5,781)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,229,409	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	496,249	31
32	Health Care	1,048,906	32
33	General Administration	540,941	33
	B. Capital Expense		
34	Ownership	168,989	34
	C. Ancillary Expense		
35	Special Cost Centers	541	35
36	Provider Participation Fee	23,543	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,279,169	40
41	**Income before Income Taxes (line 30 minus line 40)****	(49,760)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (49,760)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,138	2,275	$ 48,275	$ 21.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,940	5,244	130,117	24.81	3
4	Licensed Practical Nurses	7,392	8,195	153,783	18.77	4
5	Nurse Aides & Orderlies	29,609	30,916	390,150	12.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,878	1,893	18,628	9.84	10
11	Social Service Workers	3,821	3,851	56,139	14.58	11
12	Dietician					12
13	Food Service Supervisor	1,737	1,837	26,552	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,478	12,095	106,205	8.78	15
16	Dishwashers					16
17	Maintenance Workers	1,752	1,774	29,957	16.89	17
18	Housekeepers	9,774	10,592	95,179	8.99	18
19	Laundry					19
20	Administrator	1,515	1,544	51,557	33.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	503	513	8,423	16.42	23
24	Clerical	1,268	1,290	17,101	13.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	77,805	82,019	$ 1,132,066 *	$ 13.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	132	$ 6,266	1.3	35
36	Medical Director				36
37	Medical Records Consultant	28	1,723	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	72	650	10.3	39
40	Physical Therapy Consultant	654	46,268	10A.3	40
41	Occupational Therapy Consultant	359	22,130	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	138	8,570	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	51	4,401	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,434	$ 90,008		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas A Novy	Administrator	0	$ 50,137
Gregory W Green	Administrator	0	1,420
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 51,557

B. Administrative - Other

Description	Amount
Management Expense	$ 104,652
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 104,652

C. Professional Services

Vendor/Payee	Type	Amount
Tobin, Merritt	Interim Administrator Staffing Service	$ 44,172
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 44,172

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,000
Unemployment Compensation Insurance	7,200
FICA Taxes	83,697
Employee Health Insurance	72,750
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	4,698
Employee Physicals	1,310
Employee Uniforms	321
Home Office Allocation	10,647
TOTAL (agree to Schedule V, line 22, col.8)	$ 219,623

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 82
Advertising: Employee Recruitment	9,912
Health Care Worker Background Check (Indicate # of checks performed)	
Software Support & Maint Fees	3,866
IHCA Dues	3,901
Miscellaneous Fees	1,014
Subscriptioons	274
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,049

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,902
Seminar Expense	7,022
Home Office Allocation	3,629
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,553

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Beulah Land Christian Home **#** 0006767 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA -$ 3901**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **0**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **0**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,230** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **23,543**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **425**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Beulah Land Christian Home
Allocation on Benefits 6/30/2003 kdb 11/4/2005

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	Benefit Percentage	Employee Uniforms	Employee Expense	Employee Physicals	
53,367.97	4,344.00	23,496.00	43,125.00					
9,900.59	1,056.00	5,736.00	5,250.00	5,181.93				
7,100.88	804.00	4,332.00	6,750.00	2,303.09				229,578.87
2,475.14	168.00	912.00	4,500.00	1,671.69				
5,403.59	492.00	2,700.00	9,000.00	4,461.66				
5,448.89	336.00	1,824.00	4,125.00	6,984.34	320.71	4,698.39	1,310.00	
83,697.06	7,200.00	39,000.00	72,750.00	20,602.71	320.71	4,698.39	1,310.00	229,578.87

Less Benefits: 20,602.71
Line 3.22.3 208,976.16

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